

E-filing via AQS

for

Department of Defense

Presentation adapted from a DOL presentation

Forms available through AQS e-File

- CA-3 - Report of Work Status
- CA-7 - Claims for Compensation
- CA-7a - Time Analysis Form
- CA-7b - Leave Buy Back Worksheet

Forms available through AQS e-File

- CA-3 - Only forms submitted through e-File process will be accepted. **No hard copy forms will be processed**
- CA-7, CA-7a, CA-7b - Either hard copy **OR** e-File forms will be accepted
- Just like CA-1s and CA-2s, the Agency must retain the original signed version of the CA-7, CA-7a, CA-7b form in the employees case file

Benefits of e-Filing

- Agency (through the Agency Query System) and claimants (through the Claimant Query System) will know within 24 hours whether OWCP has received an e-Filed CA-7
- E-Filing CA-3s will reduce the possibility and/or severity of overpayments
- The CA-3 will also reduce the number of RTW cases placed into early nurse case management due to quicker input of RTW info

Applying for e-File

- AQS Users will have to complete a Non-Disclosure Form requesting e-filing access. The form is available on the ICUC Web page
- The AQS User signs the Non-Disclosure Form
- The signed form is faxed to CPMS ICUC Division
- The user's AQS status is verified and the form is completed and signed by the ICUC POC
- The completed form is sent to DOL. DOL will then send back a notification confirming the AQS user is set up to use e-File.

Actually e-Filing the forms

The ICPA will login to AQS and pull up the case for which a form will be filed

There will be a link at the bottom of the AQS page titled **“E-File CA-Form”**. Clicking on the link will start the e-Filing process

Microsoft Internet Explorer provided by US Department of Labor - ESA

Search Favorites Links Go

dol-esa.gov/AQS/resources/list.do

nt Location XIN - 10/31/2008 - CASE TRANSFER IN TRANSIT

us Location OLI - 10/31/2008 - SECURITY

of Pay was not elected Case Created: 05/16/2005

Terminated Reviewed: 05/16/2005

been controverted Closed:

gan: Reopened: 10/28/2008

On: 10/31/2008 Retired:

use of Injury 99 - CAUSE UNKNOWN

ure of Injury TS - SPRAIN/STRAIN OF LIGAMENT, MUSCLE, TENDON, NOT BACK

al Location 99 - OTHER

ent of Injury 2 - First Aid

★ AUTHORIZATION FOR MEDICAL TREATMENT ★

CA-16 Authorized Medical Treatment Period

From Date - To Date

NEW CASE Compensation Payments Compensation Tracking

Bill Inquiry **E-File CA Form**

Internet

Actually e-Filing the forms

At this point, the ICPA can select from the various form options

Clicking on the desired form will open that form

CA Forms - Microsoft Internet Explorer provided by US Department of Labor - ESA

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Refresh Print Mail Download Upload Links Go

Address <https://aqsweb.dol-esa.gov/AQ5/resources/caform.do>

9999 - OTH/UNS COMPLICATIONS MEDICAL CARE 9999 - OTHER AND UNSPECIFIED COMPLICATIONS OF MEDICAL CARE

Form Rev'd: CA1 - 05/16/2005 Location: Hearings and Review CEID: CC1 Injury ZIP: 20260

★ ★ ★ **CASE STATUS**

Adjudication Status	AM	- 10/28/2008 -	Accepted - Medical Payments Only
Current Case Status	MC	- 10/28/2008 -	Medical Benefits Only
Current Location	XIN	- 10/31/2008 -	CASE TRANSFER IN TRANSIT

→

- [CA7 Form](#)
- [CA7A Form](#)
- [CA7B Form](#)
- [CA3 Form](#)

The E-File CA Forms application requires Microsoft Internet Explorer browser, Version 6.0 or higher.

Done Internet

What the ICPA will see

The ICPA will then complete the form and click

“Submit”

CA7 Form - Microsoft Internet Explorer provided by US Department of Labor - ESA


File Edit View Favorites Tools Help

Back Forward Stop Reload Home Search Favorites Links Go

Address https://aqsweb.dol-esa.gov/AQS/resources/CAForm_7.do

Claim for Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



SECTION 1 **EMPLOYEE PORTION**

a. Name of Employee	Last	First	Middle	OMB No: 1215-0103
	TESTCASE	TESTCASE		Expires: 09/30/2011

b. Mailing Address(Including City State, ZIP Code)	c. OWCP File Number
123 UNION	502500000
BOSTON MA 01752	

d. Date of Injury	e. Social Security Number
Month Day Year	999-99-9991
05/01/2005	

E-Mail Address(Optional)

SECTION 2 Compensation is claimed for:

Inclusive Date Range	f. Telephone No./FAX No.
From To Intermittent?	

a. ☐ Leave without pay ☐ Yes ☐ No Go to Section 3

Done Internet

What the ICPA will see


A pop-Up will appear denoting that

Form Submission was Successful

https://esa-cen-tcqs01.esadev.dol.gov:9444 - CAForm - Microsoft Internet Explorer

File Edit View Favorites Tools Help

CA7a Form is submitted successfully ←

 **AQS Case Compensation Payment History** ★ ★ ★ [Logout](#)

AGENCY: 510000 - UNITED STATES POSTAL SERVICE, HEADQUARTERS & HQ FIELD UNITS
CASE#: 502500000
NAME: TESTCASE, TESTCASE
Address: 123 UNION
City State Zip: BOSTON, MA 01752
Occupation: A0462 - FORESTRY TECHNICIAN

MASTER: SSN: 111-22-3333
DOB/Age: DOI: 05/01/2005
SEX:

Reported Condition: 9999 - OTH/UNS COMPLICATIONS MEDICAL CARE
Condition Accepted

Form Rcv'd: CA1 - 05/16/2005
Location: National Office
CEID: BAA
Injury ZIP: 20260

★ ★ ★ **CASE STATUS**

Adjudication Status ● AP - 08/20/2008 - Accepted - Periodic Roll Payment
Current Case Status ● PR - 08/20/2008 - Payment on Periodic Roll
Current Location ● OLI - 05/16/2005 - SECURITY

• [CA7 Form](#)
• [CA7A Form](#)

Done Internet

How will the ICPA know it worked?

In addition to the immediate pop-up alerting the ICPA that the submission was successful, AQS will update the Payment Tracking page within 24 hours

Case Compensation Tracking - Microsoft Internet Explorer provided by US Department of Labor - ESA

File Edit View Favorites Tools Help

Back Forward Stop Home Search Favorites Refresh Print Mail News Go

Address <https://aqsweb.dol-esa.gov/AQS/resources/tracking.do>

AQS Case Compensation Tracking ★★★★★ Logout

AGENCY: 141000 - OTHER ESTABLISHMENTS, BICENTENNIAL COMMISSION
CASE#: 069000099
NAME: DOE, JOHN
Address: 1234 MAIN STREET
City State Zip: JACKSONVILLE, FL 32204
Occupation: -

MASTER: SSN: 111-22-4444 SEX: M
DOB/Age: 01/01/1930 - 78
DOI: 03/23/2008

Reported Condition: 9999 - OTH/UNS COMPLICATIONS MEDICAL CARE
Form Rcv'd: CA1 - 04/23/2008
Location: Jacksonville
CEID: ADD
Injury ZIP: 32204

Condition Accepted: 9999 - OTHER AND UNSPECIFIED COMPLICATIONS OF MEDICAL CARE

★★★★★ **CASE STATUS**

Adjudication Status ● AC - 07/24/2008 - Accepted - COP Elected
Current Case Status ● MC - 07/24/2008 - Medical Benefits Only
Current Location ● OLI - 07/24/2008 - DESC MISSING

★★★★★ **COMPENSATION PAYMENT TRACKING** ★

Comp Payment Period From - To	Date CA-7 Received by OWCP	Decision Code, Date, & Description	Date IW Signed
05/12/2008 - 05/30/2008	2008-07-23	- Undecided	2008-04-20

● [NEW CASE](#) ● [Compensation Payments](#) ● [Compensation Tracking](#)
● [Bill Inquiry](#)

Done Internet

Pre-Populated Fields on CA-7

Pre-Populated Fields in Section 1

All pre-populated fields will be in Section 1 of Form CA-7 (pictured below). The pre-populated sections will be in fields “a” through “e” of Section 1.

- * Note that the E-Mail section of field “b” will not be pre-populated and will remain blank, but editable.
- * Item “f” was left out because there may not always be a telephone number on file. OWCP didn’t want to create errors if no number was on file.

Claim for Compensation

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs



SECTION 1

EMPLOYEE PORTION

a. Name of Employee			Last		First		Middle		OMB No. 1215-0103 Expires: 10/31/2008	
b. Mailing Address (Including City State, ZIP Code)									c. OWCP File Number	
E-Mail Address (Optional)									d. Date of Injury Month Day Year	
SECTION 2 Compensation is claimed for:									e. Social Security Number	
Inclusive Date Range From To									f. Telephone No./FAX No.	
Intermittent?										

Major Differences Web form vs. Paper

Section 5 (Dependents). On the web form, the AQS user is asked to enter the dependent's **Last Name, First Name and Middle Initial**, in that particular order. This is different than the paper form, which only asks for the dependent name(s). Since there is no format to follow on the paper form, most people usually handwrite the first name followed by the last name, but on the web form DOL asks that your ICPAs please follow the format described above and depicted in the screen shot below.

Retirement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim?

☐ Yes - Complete Sections 5 through 7 or a new SF-1199A to reflect change(s) ☐ No - Complete Section 7

SECTION 5 List your dependents (including spouse):

Last	First	Middle	Social Security	Date of Birth	Relationship	Living with you?
						Yes No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>

Enter Dependent Last Name

For dependents not living with you, complete items a and b below.

a. Are you making support payments for a dependent shown above? ☐ Yes ☐ No If Yes, support payments are made to:

Major Differences Web form vs. Paper

Above Section 8. At the top of the second page on the paper form, filers are advised that they need not complete Sections 8 through 15 if the CA-7 is a subsequent submission. For ease of electronic filing, the web form asks the AQS users to check a box indicating whether the submission is for an initial form or a subsequent form. If the AQS user checks the “Initial” box, Sections 8 through 15 are required fields. If the AQS user checks the “Subsequent” box, only Sections 12 through 15 are required.

Address https://aqsweb.dol-esa.gov/AQS/resources/CAForm_7.do Go

Form CA-7
Rev. June 2005

Employing Agency Portion

For first CA-7 claim sent, complete sections 8 through 15.
For subsequent claims, complete sections 12 through 15 only.

Is this the initial or a subsequent CA-7 ? Initial ☐ Subsequent ☐

SECTION 8	Show Pay Rate as of	Additional Pay	Additional Pay	Additional Pay
Date of Injury:	Base Pay	Type	Type	Type
Date: 05/01/2005	\$ per	\$ per	\$ per	\$
Grade:	Step:			

Fields on CA-7a

Pre-Populated Sections:

1. Name of Employee
2. SSN
3. OWCP File No.

Required Sections:

Dates and Signatures

1. Name of Employee: (Last, First, Middle)		2. SSN	3. OWCP File Number

4. Period Covered by This Form:

From: 	To: 	5. Total Hours Claimed
		for LWOP:
		for Leave BuyBack:

6. In "Type of Leave Used" column, use codes "S" = Sick, "A" = Annual, "O" = Other. If Compensation is claimed for date, indicate "Yes" in "Compensation Claimed" column.

Date(s)	Compensation Claimed?	Number of Hours				Type of Leave Used	Reason for Leave Use/Remarks (e.g., doctor visit, therapy, etc.)
		LWOP	Worked	Hol	Leave		
Totals							

7. Agency Statement/Certification: I certify the above is accurate, except as follows:

Signature of Claimant	Date Signed

Signature of Agency Official

Date Signed

Fields on CA-7b

Pre-Populated Sections:

1. Name of Employee
2. SSN
3. OWCP File No.

Leave Buy Back (LBB) Worksheet/
Certification and Election

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



Employee Statement - Please carefully read instructions on pages 3 and 4 before filling out this form.

A. Name of Employee: (Last, First, Middle)

B. OWCP File Number:

C. Social Security Number:

Required Sections:

Dates and Signatures

Fields on CA-3

Pre-Populated Sections:

- OWCP Case No.
- Claimant's Name
- DOI

Required Sections:

- Agency
- Injury Compensation Specialist/Date
- Phone

REPORT OF WORK STATUS

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



To the Employing Agency: This form should be completed and submitted to OWCP each time a claimant stops work, reduces their work hours or returns to work following a work-related injury. The form should be completed even if the claimant has not yet filed form CA-7 or CA-2a. **This form does not replace form CA-7 or CA2a.**

OWCP CASE# _____ CLAIMANT'S NAME: _____ DOI _____

COP WORK STATUS INFORMATION

1. DATE STOPPED WORK (during COP): _____ (Include reductions in work schedule)
☐ Stopped Work After CA-1 FILED but During COP Eligibility Period
2. RETURN TO WORK DATE (during COP): _____ (Must complete RTW Section below)

THE CLAIMANT RETURNED TO WORK WITH THE FOLLOWING STATUS:

- ☐ Full Time Regular Duty: No Restrictions
- ☐ Full Time Modified Duty: With Restrictions
- ☐ Part Time Regular Duty: No Restrictions for _____ Hours per Day
- ☐ Part Time Modified Duty: With Restrictions for _____ Hours per Day

POST COP INFORMATION

1. DATE EMPLOYEE STOPPED WORK: _____ (Include reductions in work schedule)
 2. REASON FOR WORK STOPPAGE:
 - ☐ WITHDRAWAL OF LD
 - ☐ RECURRENCE of Temporary Total Disability (TTD)
 - ☐ ADMINISTRATIVE (explain) _____
 - ☐ OTHER (explain) _____
 - ☐ SURGERY ☐ YES ☐ NO SURGERY DATE _____
- CA-7 FILED? ☐ YES ☐ NO CA-2a FILED ☐ Yes ☐ NO
3. RETURN TO WORK DATE: _____ (Must complete RTW Section below)

THE CLAIMANT RETURNED TO WORK WITH THE FOLLOWING STATUS:

- ☐ Full Time Regular Duty: No Restrictions
- ☐ Full Time Modified Duty: With Restrictions
- ☐ Part Time Regular Duty: No Restrictions for _____ Hours per Day
- ☐ Part Time Modified Duty: With Restrictions for _____ Hours per Day

- JOB OFFER ACCEPTED ON: _____ (Please forward copy to OWCP)
- WORK RESTRICTIONS HAVE CHANGED. SEE MEDICAL DATED _____

NOTES: _____

EMPLOYER INFORMATION

AGENCY _____

INJURY COMPENSATION SPECIALIST/DATE _____

PHONE _____